

Concluding Commentary

Simplicity matters: Using system-level changes to encourage clinician intervention in helping tobacco users quit

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The articles in this supplement explore the fundamental problem of how to design systems-level changes that make it easier for clinicians to help more tobacco users quit. Smoking remains a huge problem among Americans, with 46 million still smoking and 440,000 dying each year from smoking-related illness (Schroeder, 2004). Another 8.6 million are debilitated by tobacco-caused diseases (Centers for Disease Control and Prevention, 2000). Seventy percent of smokers want to quit, but few succeed, and advice from a health professional can double their chances of quitting (Fiore et al., 2000). Even so, most clinicians do not intervene with smoking patients, though this single step could lengthen and improve many patients' lives. When asked why they do not intervene, clinicians offer at least eight reasons: (1) They are too busy; (2) they lack expertise in smoking cessation; (3) they have no financial incentive to do so; (4) they know most smokers won't succeed in quitting; (5) they think smoking is the smokers' own fault; (6) they respect smokers' privacy and don't want to interfere; (7) they are afraid of scaring away patients with a negative message; and (8) they themselves smoke. (<http://smokingcessationleadership.ucsf.edu>)

None of these reasons justify failing to offer this beneficial health advice, and each can be easily rebutted. Too busy? Effective interventions such as referring smokers to quitlines require only seconds. Lack expertise? Little expertise is needed to refer a

patient to a quitline or other evidence-based treatment service. Not paid? This should be part of the basic service for any office visit. Small chance of success? With help from a clinician, quitting attempts double, and quitlines can double or triple cessation rates (Zhu et al., 2002). Stigma attached to smokers? Most tobacco users became dependent in their youth, and nicotine is notoriously addictive. (Ossip-Klein et al., 2003) Privacy concerns? More than valuing their privacy, patients want clinicians to be concerned about their health. Afraid of scaring off patients? Studies verify that smokers, even those not intending to quit, want to be encouraged to quit by health professionals (Barzilai, Goodwin, Zyzanski & Stange, 2001). Many smokers are concerned about the effects of secondhand smoke on their loved ones, and most know about the effects of smoking on their own health and are worried about it. Clinicians who themselves use tobacco? Fewer do all the time, and those that do also need help and support in quitting. (<http://smokingcessationleadership.ucsf.edu>)

The possibility of mobilizing large armies of clinicians of all kinds—not just physicians and dentists, but dental hygienists, respiratory therapists, nurses, physicians' assistants, pharmacists, pharmacy technicians, mental health counselors and many others—offers hope of driving down the number of tobacco users dramatically. This requires creative changes in the systems in which these professionals operate and requires changing institutional practices.

Researchers and system reformers now have a keener appreciation of what is needed to help clinicians' encourage patient behavior change. Wagner's Chronic Care Model (Wagner, 1998) details system characteristics that optimize patient-provider

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interactions for quality chronic care. The studies in the present supplement explore a variety of such changes. A few findings surface as promising, while others prove disappointing.

The systems changes presented here range from simple to complex; they improved patient tobacco cessation outcomes to varying degrees. One lesson that can be derived is that, generally, the simpler the intervention, the more likely it is to succeed. This confirms preliminary observations at the Smoking Cessation Leadership Center involving a variety of clinician associations and health care institutions, indicating that simple steps can increase clinician motivation to help patients quit tobacco.

One of the studies in this supplement, "Tobacco attitudes, practices, and behaviors: A survey of dentists participating in managed care," by Albert and colleagues, reported that dentists do not routinely intervene with their patients who use tobacco. In a study of the use of the 5A's model (ask, advise, assess, assist, arrange; Fiore et al., 2000), practitioners recorded tobacco use in patients' charts less than 40% of the time and generally showed a less than keen interest in helping tobacco users quit. Although self-reported lack of knowledge of the guideline was high, 70% said that their lack of knowledge either was not a barrier or was only a slight barrier to incorporating tobacco cessation into their practices. Clearly, education is not necessarily the key to changing practitioner behavior in this area, and other approaches are needed as well.

An interesting alternative could be based on a project the Smoking Cessation Leadership Center (SCLC) initiated in 2003 with the American Dental Hygienists' Association. This project, looks beyond the dentist to others working in the dental office and aims to double to about 50% over 3 years the proportion of hygienists nationwide who intervene to help tobacco-using patients quit. The hygienists use an abbreviated approach dubbed "ask, advise, refer" to identify tobacco users and route them to the nearest quitline or cessation Web site (www.askadviserefer.org). SCLC staff and partners have found nearly universal interest among many different groups of health professionals in trying this simple approach to intervening with patients who use tobacco. Its simplicity has been amplified with the creation of a single toll-free telephone number, 1-800-QUIT NOW, supported by the National Cancer Institute, which anyone can call to be directed to a tobacco quitline.

Such broad strategies can help, but encouraging clinician interventions on tobacco cessation remains a relatively new frontier. Even knowledge of how well clinicians are doing in helping patients with tobacco cessation is problematic. Another of the studies published here, Conroy and colleagues' "Measuring provider adherence to tobacco treatment

guidelines: A comparison of electronic medical record review, patient survey and provider survey," found little agreement among three methods of measuring primary care providers' actions with respect to tobacco counseling. Implementing an electronic records review system does not, in itself, automatically increase provider documentation of tobacco interventions but might encourage better clinician practice. A striking discordance was documented between patient and provider perceptions of just what cessation services were delivered. Electronic records often provided information that matched neither patient nor provider recollection of what happened during the visit. Both providers and patients overestimated the frequency of tobacco cessation interventions. Generally, studies have shown that providers overestimate how often they counsel smokers in surveys but underdocument in paper records their counseling about health behaviors. The authors suggest that using an electronic, rather than paper, medical record does not by itself solve the underdocumentation problem. The only point of congruence in the study is the "ask" step, which was documented at a substantial rate. This implies that providers might be more inclined to follow a simplified approach. An intervention made as simple as possible for clinicians—including having other office staff do the asking, advising, and referring—could open the door to more comprehensive future interventions.

Another study, Fisher and colleagues' "Improving clinic- and neighborhood-based smoking cessation services within federally qualified health centers serving low-income, minority neighborhoods," used a comprehensive chronic care model to examine four systems changes in federally qualified health centers: (1) documenting smoking status and readiness to quit, (2) instituting an electronic records system, (3) paying for cessation medications, and (4) creating a system of neighborhood coaches or liaisons. Electronic medical record documentation of smoking status and stages of readiness to quit dramatically improved clinicians' intervention behavior. Electronic documentation of smoking status and readiness to quit increased from 2% of encounters in the first 3 months to 94% in the last 3 months of the 2-year programs and was maintained at more than 90% the following year. This systems change, coupled with other changes, triggered additional improvements in clinician interventions, including more recommendations to quit and more encouragement to use pharmaceutical cessation aids. Although the study is encouraging, large-scale replication would be difficult, since multifaceted, comprehensive change across systems is challenging to implement. Additionally, a comparison clinic showed significant improvements without the benefit of added services.

Overall, these studies contribute to the body of knowledge about what works, what doesn't work, and what demands more study in the effort to maximize clinician involvement in tobacco cessation. Simple, attainable interventions that can make a difference are optimal, even though changing clinician behavior is a complex and sometimes counter-intuitive process. Education and training alone are insufficient; in addition, the system must be optimized to encourage clinicians' behavior change.

A realistic plan for improving clinician performance over time might call for a two-tiered approach, with those who are willing and able implementing the full 5A's protocol approach with every patient who uses tobacco. At a minimum, all clinicians should determine the tobacco use status of every patient, should advise smokers to quit, and should refer them to a quitline or other cessation services. This brief process could ultimately save many lives while raising both patient and provider awareness of this critical health problem.

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